		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0002923

Facility Name: Heartland Manor Nursing Center

Address: 410 N.W. Third St. (Number) Casey (City) 62420 (Zip Code)

County: Clark

Telephone Number: (217) 932-4081 **Fax #** (217) 932-4922

IDPA ID Number: 370860567001

Date of Initial License for Current Owners: 12/18/64

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael G. Kaplan **Telephone Number:** (312) 207-2264
Altschuler, Melvoin & Glasser LLP
30 South Wacker Drive
Chicago, IL 60606-7494
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/99 to 06/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, 30 South Wacker Drive, Chicago, Il 60606-7494
(Telephone) (312) 207-2264 Fax # (312) 207-2958

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,237	31	1,580	2,848	8
9	SNF/PED					9
10	ICF	12,873	8,477		21,350	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,110	8,508	1,580	24,198	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.78%

D. How many bed-hold days during this year were paid by Public Aid?
N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 12/18/1964

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 1,580

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	173,311	10,790	5,531	189,632		189,632		189,632			1
2	Food Purchase		97,443		97,443		97,443	(12,896)	84,547			2
3	Housekeeping	82,641	14,723	304	97,668		97,668		97,668			3
4	Laundry	51,501	16,388	222	68,111		68,111		68,111			4
5	Heat and Other Utilities			69,514	69,514		69,514		69,514			5
6	Maintenance	31,792	4,251	31,687	67,730		67,730		67,730			6
7	Other (specify):*											7
8	**TOTAL General Services**	339,245	143,595	107,258	590,098		590,098	(12,896)	577,202			8
	B. Health Care and Programs											
9	Medical Director			4,500	4,500		4,500		4,500			9
10	Nursing and Medical Records	831,082	48,762	4,845	884,689		884,689		884,689			10
10a	Therapy		22,902	93,720	116,622		116,622		116,622			10a
11	Activities	34,155		3,369	37,524		37,524		37,524			11
12	Social Services	18,965		2,205	21,170		21,170		21,170			12
13	Nurse Aide Training			1,750	1,750		1,750		1,750			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	884,202	71,664	110,389	1,066,255		1,066,255		1,066,255			16
	C. General Administration											
17	Administrative	67,458			67,458		67,458		67,458			17
18	Directors Fees											18
19	Professional Services			31,319	31,319		31,319		31,319			19
20	Dues, Fees, Subscriptions & Promotions			8,026	8,026		8,026	(585)	7,441			20
21	Clerical & General Office Expenses	66,379	7,105	11,582	85,066		85,066	(2,158)	82,908			21
22	Employee Benefits & Payroll Taxes			285,288	285,288		285,288		285,288			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,190	5,190		5,190		5,190			24
25	Other Admin. Staff Transportation			386	386		386		386			25
26	Insurance-Prop.Liab.Malpractice			31,544	31,544		31,544		31,544			26
27	Other (specify):*											27
28	**TOTAL General Administration**	133,837	7,105	373,335	514,277		514,277	(2,743)	511,534			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,357,284	222,364	590,982	2,170,630		2,170,630	(15,639)	2,154,991			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**** See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Heartland Manor Nursing Center #0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7 **	8	9	10	
30	Depreciation			88,205	88,205		88,205	(1,673)	86,532			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,947	20,947		20,947	(791)	20,156			32
33	Real Estate Taxes			1,940	1,940		1,940	(1,940)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,034	2,034		2,034		2,034			35
36	Other (specify):*											36
37	**TOTAL Ownership**			113,126	113,126		113,126	(4,404)	108,722			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	26,664	64,808	3,351	94,823		94,823		94,823			39
40	Barber and Beauty Shops			212	212		212		212			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,352	54,352		54,352		54,352			42
43	Other (specify):* **Nonallowable costs**			33,639	33,639		33,639	(33,639)				43
44	**TOTAL Special Cost Centers**	26,664	64,808	91,554	183,026		183,026	(33,639)	149,387			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,383,948	287,172	795,662	2,466,782		2,466,782	(53,682)	2,413,100			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(895)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(791)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(26,249)	43		24
25	Fund Raising, Advertising and Promotional	(498)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(87)	20		28
29	Other-Attach Schedule	(25,162)	var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (53,682)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	-		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (53,682)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5A

Heartland Manor Nursing Center

ID# 0002923

Report Period Beginning: 07/01/99

Ending: 06/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
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76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V		N/A						3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6			N/A								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5		N/A								5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Union Planters Bank		X	New wing	4,545.00	12/1996	$ 510,000	$ 228,175	10/01/2016	0.0875	$ 19,760	1
2												2
3												3
4	Lease obligations		X	Telephone system	243.00	9/1998	7,636	2,777	08/01/2001	0.0896	378	4
5	Lease obligations		X	Dishwasher	59.00	6/25/99	2,420	2,148	05/25/2004	0.1612	809	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				4,847.00		$ 520,056	$ 233,100			$ 20,947	9
	B. Non-Facility Related*											
10								Less: Interest income offset			(791)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (791)	14
15	TOTALS (line 9+line14)						$ 520,056	$ 233,100			$ 20,156	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center **#** 0002923 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,047 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care	152,472	1964	$ 24,000	1
2					2
3	TOTALS	152,472		$ 24,000	3

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	78		1964	1964	$ 358,838	$	25	$	$	$ 358,838	4
5			1966	1966	21,735		25			21,735	5
6			1970	1970	3,400		25			3,400	6
7			1972	1972	5,782		25			5,782	7
8			1971	1971	6,016		25			6,016	8
	Improvement Type**										
9	Building improvements			1973	7,124		10			4,127	9
10	Building improvements			1974	28,947	910	14-30	910		25,291	10
11	Building improvements			1975	7,321		10-30			7,321	11
12	Building improvements			1976	1,520	28	10-30	28		1,354	12
13	Building improvements			1977	1,684		7			1,684	13
14	Building improvements			1978	16,114		5-15			16,114	14
15	Building improvements			1979	3,888		10			3,888	15
16	Building improvements			1980	3,223		7			3,223	16
17	Building improvements			1981	1,376		7			1,376	17
18	Building improvements			1982	13,986		3-30			13,986	18
19	Building improvements			1983	6,619		5			6,619	19
20	Building improvements			1984	18,714		5-15			18,714	20
21	Building improvements			1985	8,579	858	5-15	858		5,181	21
22	Building improvements			1986	45,792	4,580	10-20	4,580		30,564	22
23	Building improvements			1987	28,030	2,803	5-15	2,803		27,452	23
24	Building improvements			1988	5,444	363	12-15	363		4,536	24
25	Building improvements			1989	3,775	251	15	251		2,704	25
26	Building improvements			1990	1,151	51	7	51		1,151	26
27	Building improvements			1991	7,180	583	10	583		7,180	27
28	heating/air system			1992	80,277	4,014	20	4,014		28,432	28
29	Building improvements			1992	3,084	308	10	308		2,621	29
30	Building improvements			1992	2,168	217	10	217		1,825	30
31	wallpaper			1992	308	31	10	31		257	31
32	Building improvements			1992	647	65	10	65		518	32
33	Building improvements			1992	4,263	284	15	284		2,202	33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 696,985	$ 15,346		$ 15,346	$	$ 614,091	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	21		1996	1996	$ 828,949	$ 20,724	40	$ 20,724	$	$ 82,897	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ceiling/floor			1992	49,925	1,872	20	1,872		18,411	9
10	sprinkler system			1992	60,121	2,255	20	2,255		23,046	10
11	storage shelving			1993	4,090	307	10	307		3,033	11
12	storage shelving			1993	1,003	75	10	75		752	12
13	resident security system			1993	3,909	147	20	147		1,449	13
14	cabinets			1993	42,611	1,603	15-20	1,603		15,646	14
15	heating/air/tubs			1993	29,226	1,096	20	1,096		9,916	15
16	fire alarm system			1993	12,350	463	20	463		4,374	16
17	plumbing and water system			1993	8,684	326	20	326		3,148	17
18	cubicle tracking			1993	1,768	133	10	133		1,282	18
19	building improvements			1994	9,921	372	20	372		3,105	19
20	building improvements			1995	28,132	2,053	10-20	2,053		8,490	20
21											21
22	Architect fees			1996	74,806	1,872	40	1,872		7,960	22
23	hvac/insulation/ducts			1996	30,292	759	40	759		2,532	23
24	sprinklers			1996	9,774	183	40	183		976	24
25	painting			1996	4,052	76	40	76		404	25
26	general contractor fees			1996	7,841	147	40	147		784	26
27	electrical			1996	18,390	460	40	460		1,955	27
28	chapel			1996	12,572	471	40	471		2,095	28
29	curtain tracking			1996	742	28	20	28		155	29
30	room signs			1996	3,331	125	20	125		667	30
31	lighting			1996	142	5	20	5		32	31
32	bathrooms			1996	8,610	323	20	323		1,727	32
33	sprinklers			1996	340	26	10	26		136	33
34	security locks			1996	1,049	39	20	39		209	34
35	carpeting			1996	3,436	129	20	129		687	35
36	TOTAL (lines 4 thru 35)				$ 1,256,066	$ 36,069		$ 36,069	$	$ 195,868	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	call lights			1996	1,881	71	11	71		453	9
10	air filtration			1996	2,081	78	20	78		416	10
11	wiring			1996	2,970	446	5	446		2,376	11
12	hallway support bars			1996	750	56	10	56		294	12
13	capitalized interest-new wing			1996	4,700	88	40	88		471	13
14	plumbing			1996	4,640	174	20	174		1,037	14
15	electrical work			1996	4,662	175	20	175		957	15
16	flooring			1996	2,400	90	20	90		478	16
17	courtyard			1996	2,766	104	20	104		541	17
18	concrete work entrance			1996	1,470	55	20	55		282	18
19	Building appraisal			1997	2,578	48	40	48		296	19
20	Chapel HVAC			1997	2,324	87	20	87		410	20
21	Stained glass window			1997	2,052	76	20	76		334	21
22	Steel door			1997	422	16	20	16		67	22
23	Hot water heater - North Wing			1997	3,838	144	20	144		624	23
24	Hot water heater - Laundry			1997	2,893	108	20	108		446	24
25	Hand rails			1997	5,252	197	20	197		788	25
26	Painting			1997	478	18	20	18		70	26
27	Walk in cooler			1997	11,524	432	20	432		1,680	27
28	Fire system work			1997	513	19	20	19		71	28
29	Key pad - security system			1997	360	14	20	14		51	29
30	Hot water heater - Kitchen			1997	3,508	132	20	132		482	30
31	Tile flooring - Lobby			1997	900	34	20	34		124	31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 64,962	$ 2,662		$ 2,662	$	$ 12,748	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Hot water heater			1998	7,318	274	20	274		914	9
10	Bed light installation			1998	1,826	68	20	68		213	10
11	Hand rails			1998	1,413	53	20	53		159	11
12	Sprinklers			1998	708	27	20	27		79	12
13	Generator bypass switch			1998	1,567	59	20	59		169	13
14	Carpeting in lobby			1998	727	27	20	27		51	14
15	Lighting - kitchen			1998	985	37	20	37		102	15
16	Paging system			1998	516	19	20	19		50	16
17	Room divider remodeling			1998	391	15	20	15		38	17
18	Bathroom lighting			1998	1,090	41	20	41		100	18
19	South wing remodeling			1998	165	6	20	6		14	19
20	Roof over generator room			1998	568	22	20	22		52	20
21	Bathrooms			1998	7,394	277	20	277		647	21
22	Bathrooms-South & Hutton			1998	6,197	181	20	181		491	22
23	Fire Alarm System			1999	1,317	16	20	16		82	23
24	Fire & Smoke Dampers			1999	1,664	7	20	7		90	24
25	Generator Work for Heating			1999	1,760	14	20	14		102	25
26											26
27	Generator panel			1999	2,023	118	10	118		118	27
28											28
29											29
30											30
31	Reconciling items				(6,792)	192		192		(5,606)	31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 30,837	$ 1,453		$ 1,453	$	$ (2,135)	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 368,384	$ 29,877	$ 29,877	$	5-10	$ 236,626	37
38	Current Year Purchases	17,399	1,125	1,125		5-15	1,125	38
39	Fully Depreciated Assets	89,609					89,609	39
40								40
41	TOTALS	$ 475,392	$ 31,002	$ 31,002	$		$ 327,360	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43	Resident care	1994 Ford van	1994	41,610				5	41,610	43
44										44
45										45
46	TOTALS			$ 41,610	$	$	$		$ 41,610	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,589,852	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 86,532	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 86,532	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,189,542	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Aklinski building - 1994	$ 40,045	$ 1,027	$ 6,161	52
53	Aklinski parking lot-1996	3,900	195	764	53
54	Delaware house-1998	17,550	451	1,127	54
55	Land-1994 & 1998	25,000	n/a	n/a	55
56					56
57	TOTALS	$ 86,495	$ 1,673	$ 8,052	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,034 Description: Copier - 2,034
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments		500	1,250		1,750
8	Nurse Aide Competency Tests					
9	TOTALS		$ 500	$ 1,250	$	$ 1,750
10	SUM OF line 9, col. 1 and 2	(e)	$ 1,750			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	7

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(2),(3)	hrs	$		$ 19,105	$ 6,427		$ 25,532	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			9,519			9,519	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs			64,300			64,300	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				36,816		36,816	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39(1),(2),(3)		26,664			27,992		54,656	12
13	RT Supplies Other (specify): See attached	10A(2)				3,432	16,475		16,475 3,432	13
14	TOTAL			$ 26,664		$ 96,356	$ 87,710		$ 210,730	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center **#** 0002923 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 43,265	$ 43,265	1
2	Cash-Patient Deposits	1,522	1,522	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	360,051	360,051	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,664	8,664	6
7	Other Prepaid Expenses	34,930	34,930	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See attached	25	25	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 448,457	$ 448,457	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	351	351	12
13	Land	49,000	49,000	13
14	Buildings, at Historical Cost	1,633,785	1,633,785	14
15	Leasehold Improvements, at Historical Cost	473,050	473,050	15
16	Equipment, at Historical Cost	517,002	517,002	16
17	Accumulated Depreciation (book methods)	(1,197,596)	(1,197,596)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Security deposit	59	59	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,475,651	$ 1,475,651	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,924,108	$ 1,924,108	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 88,153	$ 88,153	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,522	1,522	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	96,585	96,585	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,252	3,252	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	907	907	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 190,419	$ 190,419	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	233,100	233,100	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 233,100	$ 233,100	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 423,519	$ 423,519	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,500,589	$ 1,500,589	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,924,108	$ 1,924,108	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,506,357	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,506,357	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(5,767)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	(1)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (5,768)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,500,589	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,559,443	1
2	Discounts and Allowances for all Levels	(401,320)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,158,123	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	130,769	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 130,769	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,048	13
14	Non-Patient Meals	12,896	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	10,140	16
17	Sale of Drugs	16,693	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,170	19
20	Radiology and X-Ray	289	20
21	Other Medical Services	113,789	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 159,025	23
	D. Non-Operating Revenue		
24	Contributions	5,701	24
25	Interest and Other Investment Income***	791	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,492	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior year settlement due to Medicare	(16,245)	28
28a	Other (See attached)	22,851	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,606	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,461,015	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	590,098	31
32	Health Care	1,066,255	32
33	General Administration	514,277	33
	B. Capital Expense		
34	Ownership	113,126	34
	C. Ancillary Expense		
35	Special Cost Centers	128,674	35
36	Provider Participation Fee	54,352	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,466,782	40
41	**Income before Income Taxes (line 30 minus line 40)****	(5,767)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (5,767)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 37,637	$ 18.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,930	11,752	215,080	18.30	3
4	Licensed Practical Nurses	12,900	13,588	167,014	12.29	4
5	Nurse Aides & Orderlies	51,976	54,423	417,601	7.67	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,020	1,040	9,340	8.98	9
10	Activity Assistants	4,160	4,240	24,815	5.85	10
11	Social Service Workers	2,016	2,080	18,965	9.12	11
12	Dietician					12
13	Food Service Supervisor	2,032	2,080	19,541	9.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,029	21,187	153,770	7.26	15
16	Dishwashers					16
17	Maintenance Workers	2,000	2,080	31,792	15.28	17
18	Housekeepers	7,820	11,900	82,641	6.94	18
19	Laundry	6,905	7,337	51,501	7.02	19
20	Administrator	1,928	2,080	67,458	32.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,832	6,240	66,379	10.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	1,928	2,080	20,414	9.81	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	133,476	144,187	$ 1,383,948 *	$ 9.60	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	88	$ 5,084	1(3)	35
36	Medical Director	26	4,500	9(3)	36
37	Medical Records Consultant	24	1,500	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	1,020	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	14	715	10A(3)	43
44	Activity Consultant	20	875	11(3)	44
45	Social Service Consultant	76	2,205	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	296	$ 15,899		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	51	915	10(3)	52
53	TOTAL (lines 50 - 52)	51	$ 915		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David J. Sauer	Administrator	0.00%	$ 67,458
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 67,458

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Larsson, Woodyard & Henson	Audit	$ 13,250
Duane, Morris &Heckscher	Legal	297
Dennis Simonton	Legal	130
Altschuler, Melvoin & Glasser	Accounting	5,784
Circle of Quality	Operations consulting	969
Quorem Consulting	Retirement plan admin	2,650
American Expr. Tax & Bus. Scvs.	Accounting	1,832
Achieve Software	Computer consultation	3,622
Personnel Planners	Unemployment consultant	865
Charley, Inc.	Computer consultation	1,563
American Health Care Assn.	Operations consulting	75
Cumberland Internet Services	Communications consultant	282
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 31,319

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,530
Unemployment Compensation Insurance	7,012
FICA Taxes	105,873
Employee Health Insurance	77,330
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Profit Sharing Plan, Retirement	30,554
Employee morale	2,162
Employee life & additional health coverage	38,313
Employee physical & lab.	514
TOTAL (agree to Schedule V, line 22, col.8)	$ 285,288

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 29)	290
Ill. Health Care Association dues	3,873
NAIER	794
AHCA Facilitator fees	620
Sam's Club dues	490
Various dues & subacriptions	1,685
Various licenses & fees	274
Less: Public Relations Expense	(498)
Non-allowable advertising	
Yellow page advertising	(87)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,441

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel (see attached)	3,157
Seminar Expense (see attached)	2,033
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,190

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6					N/A								
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center **#** 0002923 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Ill. Health Care Association - 3,873**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,655** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,352**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **12,896**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Larsson, Woodyard & Henson** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit not yet complete. Copy will be forwarded upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Heartland Manor Nursing Center
Provider # 00002923
07/01/1999 to 06/30/2000

Supplementary Information

Page 5 - Non-allowable expenses: Line 29	Amount	Reference
Offset food income against cost	(12,896)	2
Promotional advertising	(6,189)	43
Other non-allowable advertising	(186)	43
Bad Debts-other	(120)	43
Non-care related depreciation	(1,673)	30
Non-care related real estate taxes	(1,940)	33
Offset misc. income against expense	(2,158)	21
	(25,162)	

Page 16 - Special services: Line 13	Column #	Amount	Reference
Respiratory therapy	5	81	10A(3)
Oxygen	5	2,094	39(3)
Laboratory	5	824	39(3)
X Ray	5	433	39(3)
		3,432	

Page 20 - Staffing & salary: Line 32	Hrs worked	Hrs paid	Amount	Hrly wage
Care plan coordinator	1,928	2,080	20,414	9.81

Page 6 - Non-Profit required attachment - List of Board of Directors:

Board Member	Directly Provided Services	Type of Service	Entity owned doing business with facility	Type of Business conducted
David Hensiek - President	no			
Betty Styer	no			
Tom March	no			
Mark Ahrens	yes	Grocery	Casey IGA	Food
Jim Niksch	no			
Marilyn Resch - Secretary	no			
Ted Perillo - Vice Pesident	yes	Pharmacy consultant	Pharmacy Shop	Drugs.

Page 17 - Balance sheet: Line 9 (Other Current Assets)	
Interest earned receivable	5
Overwithheld employee contribution	20
	25

Page 19 - Other revenue: Line 28a	
Vending income	959
Oil income	234
Cleaning income	19,500
Miscellaneous other income	2,158
	22,851